Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 1 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

<u>Notes Applicable only to Lotus users</u>

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

<u>Notes Applicable only to Excel users</u>

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw

Shortcut=
Hold down
Control Key and press m

Shortcut=
Hold down
Control Key and press q

To Stop Macro:
Hold down
Control Key and press "Break"

		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0019471

Facility Name: The Arbor

Address: 535 Elm Street (Number) Itasca (City) 60143 (Zip Code)

County: DuPage

Telephone Number: (630) 773-9416 **Fax #** (630) 773-9434

IDPA ID Number: 362848501001

Date of Initial License for Current Owners: 08/06/75

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles Fischer **Telephone Number:** 312-634-3400
Altschuler, Melvoin & Glasser LLP
One South Wacker Drive
Chicago, IL 60606-3392
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, One South Wacker Drive, Chicago, Il 60606-3392
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	76	Skilled (SNF)	76	27,816	1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	68	24,888	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	144	TOTALS	144	52,704	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			825	825	8
9	SNF/PED					9
10	ICF	24,818	21,714		46,532	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,818	21,714	825	47,357	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.85%

D. How many bed-hold days during this year were paid by Public Aid?
29 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 08/06/75

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 14 and days of care provided 825

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7 **	8	9	10	
1	Dietary	220,132	24,955	7,362	252,449		252,449		252,449			1
2	Food Purchase		207,355		207,355		207,355		207,355			2
3	Housekeeping		10,140	247,255	257,395		257,395		257,395			3
4	Laundry		6,718		6,718		6,718		6,718			4
5	Heat and Other Utilities			85,217	85,217		85,217		85,217			5
6	Maintenance		7,663	41,307	48,970		48,970	4,942	53,912			6
7	Other (specify):*											7
8	**TOTAL General Services**	220,132	256,831	381,141	858,104		858,104	4,942	863,046			8
	B. Health Care and Programs											
9	Medical Director			5,650	5,650		5,650		5,650			9
10	Nursing and Medical Records	1,708,589	131,782	382,868	2,223,239		2,223,239		2,223,239			10
10a	Therapy			58,882	58,882		58,882		58,882			10a
11	Activities	100,317	5,301	1,848	107,466		107,466		107,466			11
12	Social Services	32,919		1,485	34,404		34,404		34,404			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,841,825	137,083	450,733	2,429,641		2,429,641		2,429,641			16
	C. General Administration											
17	Administrative	128,907			128,907		128,907		128,907			17
18	Directors Fees			30,000	30,000		30,000		30,000			18
19	Professional Services			48,293	48,293		48,293	6,384	54,677			19
20	Dues, Fees, Subscriptions & Promotions			27,549	27,549		27,549	(691)	26,858			20
21	Clerical & General Office Expenses	84,719	25,237	19,053	129,009		129,009	(4,239)	124,770			21
22	Employee Benefits & Payroll Taxes			305,519	305,519		305,519		305,519			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,082	4,082		4,082		4,082			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			51,101	51,101		51,101	54,935	106,036			26
27	Other (specify):*											27
28	**TOTAL General Administration**	213,626	25,237	485,597	724,460		724,460	56,389	780,849			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,275,583	419,151	1,317,471	4,012,205		4,012,205	61,331	4,073,536			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**** See schedule of adjustments attached at end of cost report.**

Facility Name & ID Number The Arbor #0019471 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	D. Ownership											
30	Depreciation			23,715	23,715		23,715	103,818	127,533			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,427	5,427		5,427	374,424	379,851			32
33	Real Estate Taxes							49,069	49,069			33
34	Rent-Facility & Grounds			1,074,480	1,074,480		1,074,480	(1,074,480)				34
35	Rent-Equipment & Vehicles			8,086	8,086		8,086		8,086			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,111,708	1,111,708		1,111,708	(547,169)	564,539			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		17,440		17,440		17,440		17,440			39
40	Barber and Beauty Shops			12,570	12,570		12,570		12,570			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,056	79,056		79,056		79,056			42
43	Other (specify):* Nonallowable costs			31,093	31,093		31,093	(31,093)				43
44	**TOTAL Special Cost Centers**		17,440	122,719	140,159		140,159	(31,093)	109,066			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,275,583	436,591	2,551,898	5,264,072		5,264,072	(516,931)	4,747,141			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,660	30		9
10	Interest and Other Investment Income	(27,626)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,861)	43		19
20	Contributions	(350)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,375)	43		24
25	Fund Raising, Advertising and Promotional	(12,802)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,978)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached Schedule 5A	(100,123)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (156,455)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(360,476)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (360,476)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (516,931)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Arbor of Itasca, Inc.
Provider #0019471
12/31/2000 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other Non-allowable Expenses

Description	Amount	Line Reference
To disallow sales & use tax	(2,132)	43
To disallow PAC contributions	(691)	20
To adjust deferred maintenance	4,942	6
To disallow legal fees	(1,142)	19
Offset miscellaneous income	(5,631)	21
To disallow vending machine expense	(4,935)	43
To disallow extraordinary loss due to refinancing	(127,338)	32
Related organization's miscellaneous income	36,804	n/a
Total	(100,123)	

SEE ACCOUNTANTS' COMPILATION REPORT

The Arbor

ID# 0019471

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
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83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John Florina, Sr.	30.00%			Itasca Shelter Care,	Itasca	Lessor
John Florina, Jr.	10.00%			L.L.C		
Duane Jacobson	30.00%					
Charles Ricci	30.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional fees	$	Itasca Shelter Care, L.L.C.	100.00%	$ 7,526	$ 7,526	1
2	V	21	Bank charges		Itasca Shelter Care, L.L.C.	100.00%	1,392	1,392	2
3	V	26	Insurance		Itasca Shelter Care, L.L.C.	100.00%	54,935	54,935	3
4	V	30	Depreciation		Itasca Shelter Care, L.L.C.	100.00%	102,158	102,158	4
5	V	32	Interest		Itasca Shelter Care, L.L.C.	100.00%	529,388	529,388	5
6	V	33	Real estate taxes		Itasca Shelter Care, L.L.C.	100.00%	49,069	49,069	6
7	V	34	Rental income	1,074,480	Itasca Shelter Care, L.L.C.	100.00%		(1,074,480)	7
8	V	43	State replacement taxes		Itasca Shelter Care, L.L.C.	100.00%	6,340	6,340	8
9	V	n/a	Miscellaneous income		Itasca Shelter Care, L.L.C.		(36,804)	(36,804)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,074,480			$ 714,004	$ * (360,476)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	John Florina, Jr.	Administrator	Administration	10.00%	None	40	100.00	Salary	$ 106,940	L17, C1	1
2	Duane Jacobson	Owner	Administration	30.00%	None	5	12.00	Director Fees	10,000	L18, C3	2
3	Charles Ricci	Owner	Administration	30.00%	None	5	12.00	Director Fees	10,000	L18, C3	3
4	John Florina, Sr.	Owner	Administration	30.00%	None	5	12.00	Director Fees	10,000	L18, C3	4
5	Barbara Florina	Admin/Accounting	Clerical	0.00%	None	11	25.00	Wage	4,462	L21, C1	5
6	Daniel Florina	Contractor	Snow Removal	0.00%	None	varied	varied	Contract	1,413	L6, C3	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 142,815		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10		N/A								10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Cambridge		x	Mortgage	$36,889.00	01/31/00	$ 5,089,300	$ 5,067,508	02/01/35	0.0820	$ 382,895	1
2	Bloomingdale Bank & Trust		x	Mortgage	$3,500+interest	05/12/94	2,000,000		05/01/01	variable	21,019	2
3	Draper & Kramer		x	Construction	$20,821.00	07/1/91	1,964,882		02/01/03	0.1000	2,325	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$57,710.00		$ 9,054,182	$ 5,067,508			$ 406,239	9
	B. Non-Facility Related*											
10								Amortization of mortgage costs			5,550	10
11								Interest income offset			(31,938)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (26,388)	14
15	TOTALS (line 9+line14)						$ 9,054,182	$ 5,067,508			$ 379,851	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$ 54,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	$ 51,569	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,931)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 52,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 49,069	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	49,511	8
1996	49,310	9
1997	51,459	10
1998	52,881	11
1999	51,569	12

1998 Taxes Paid	52,881
1999 Taxes Paid	51,569
% Decrease	0.98

Due to real estate tax bills being consistent over past several years, use accrual of $52,000.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,391 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient care	41,000	1975	$ 9,559	1
2	Patient care	44,336	1992	10,446	2
3	TOTALS	85,336		$ 20,005	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	68		1975	1975	$ 271,012	$	40	$ 6,775	$ 6,775	$ 173,072	4
5			1975	1975	187,817		25	3,327	3,327	187,817	5
6			1975	1975	113,922		20			113,922	6
7			1975	1975	4,734		10			4,734	7
8			1975	1975	16,013		4			16,013	8
	Improvement Type**										
9	Building Improvements			1976	7,019		25	281	281	6,883	9
10	Building Improvements			1976	10,352		40	259	259	6,340	10
11	Building Improvements			1976	2,620		36	73	73	1,569	11
12	Building Improvements			1976	243		10			243	12
13	Building Improvements			1976	608		4			608	13
14	Building Improvements			1987	5,847		20			5,847	14
15	Building Improvements			1988	32,894		35	940	940	11,436	15
16	Building Improvements			1991	32,267		35	922	922	8,759	16
17	Building Improvements			1993	168,024		40	4,201	4,201	31,505	17
18	Building Improvements			1993	21,405		40	535	535	4,005	18
19	Building Improvements			1987	12,923	410	35	369	(41)	4,986	19
20	Building Improvements			1988	6,270	200	35	179	(21)	2,328	20
21	Building Improvements			1990	21,197	672	35	606	(66)	6,361	21
22	Building Improvements			1991	986	31	35	28	(3)	267	22
23	Building Improvements			1992	7,503	238	35	214	(24)	1,820	23
24	Building Improvements			1993	12,681	325	40	317	(8)	2,378	24
25	Building Improvements			1994	3,100	79	40	78	(1)	504	25
26	Building Improvements			1994	11,175	287	40	279	(8)	1,815	26
27	Building Improvements			1995	15,605		10	1,561	1,561	8,193	27
28	Cabinets			1996	2,768	89	31	89		401	28
29	Electrical Fixtures			1996	4,972	160	31	160		680	29
30	Cabinets			1996	3,097	100	31	100		408	30
31	Building Improvements			1984	12,774		10			12,774	31
32	Building Improvements			1985	7,314		10			7,314	32
33	Building Improvements			1986	4,044		8			4,044	33
34	Building Improvements			1986	1,379		8			1,379	34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,002,565	$ 2,591		$ 21,293	$ 18,702	$ 628,405	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	76		1993	1993	$ 2,533,506	$	40	$ 64,083	$ 64,083	$ 488,170	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Front Door Security System			1997	6,230	201	31	201		703	9
10	Concrete Pads for Washers			1997	4,430	143	31	143		488	10
11	Carpeting			1997	7,271	235	31	235		724	11
12	Complete Communications-Nurse Calling System			1998	4,543	147	31	147		331	12
13	New Door Opening			1999	1,798	58	31	58		111	13
14	Window Replacement			2000	4,801	13	31	13		13	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 2,562,579	$ 797		$ 64,880	$ 64,083	$ 490,540	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 389,197	$ 18,928	$ 39,961	$ 21,033	5-10 years	$ 267,524	37
38	Current Year Purchases	16,901	1,399	1,399		5-7 years	1,399	38
39	Fully Depreciated Assets	159,472				5-10 years	159,472	39
40								40
41	TOTALS	$ 565,570	$ 20,327	$ 41,360	$ 21,033		$ 428,395	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient care	1985 Dodge Maxi Van	1985	$ 17,063	$	$	$	5 years	$ 17,063	42
43										43
44										44
45										45
46	TOTALS			$ 17,063	$	$	$		$ 17,063	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 4,167,782	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 23,715	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 127,533	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 103,818	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,564,403	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 1/1/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Itasca Shelter Care, L.L.C. - See Page 6

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [x] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ None Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	1999 Seville	$ 673.84	$ 8,086	17
18					18
19					19
20					20
21	TOTAL		$ 673.84	$ 8,086	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	$	415	$ 24,773	$	415	$ 24,773	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		49	2,772		49	2,772	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		420	31,337		420	31,337	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				16,998		16,998	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab	L39, C2					442		442	13
14	TOTAL			$	884	$ 58,882	$ 17,440	884	$ 76,322	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 1/1/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 129,988	$ 401,553	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 35,000)	503,926	503,926	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	57,532	57,532	6
7	Other Prepaid Expenses	5,889	5,889	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Escrows & Repl. Reserves		281,122	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 697,335	$ 1,250,022	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		20,005	13
14	Buildings, at Historical Cost		3,039,771	14
15	Leasehold Improvements, at Historical Cost	116,435	525,373	15
16	Equipment, at Historical Cost	339,498	582,633	16
17	Accumulated Depreciation (book methods)	(296,981)	(1,564,403)	17
18	Deferred Charges		5,242	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): Mtg. Costs		206,374	22
23	Other(specify): Deferred Costs - Apartments		1,272	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 158,952	$ 2,816,267	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 856,287	$ 4,066,289	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 157,881	$ 157,881	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,750	35,750	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	98,563	98,563	30
31	Accrued Taxes Payable (excluding real estate taxes)	854	854	31
32	Accrued Real Estate Taxes(Sch.IX-B)		52,000	32
33	Accrued Interest Payable		34,628	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 293,048	$ 379,676	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,067,508	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,067,508	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 293,048	$ 5,447,184	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 563,239	$ (1,380,895)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 856,287	$ 4,066,289	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (68,029)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (68,029)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	269,040	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(261,481)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Shareholders' Contributions**	623,709	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 631,268	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 563,239	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

The Arbor of Itasca
Provider # 0019471
12/31/2000
Schedule 19A
Schedule B XVII - Income Statement
Reconciliation of Taxable Income to Net Income

Net Income	$ 269,040
Expenses on Book not in return	
Nondeductil	350
Deductions not charged against book income	
Accrued Sh	(2,400)
Depreciatio	(5,013)
Amortizatio	(196)
Taxable Inc	$ 261,781

See Accountants' Compilation Report

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,360,238	1
2	Discounts and Allowances for all Levels	(87,133)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,273,105	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	97,241	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 97,241	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	13,482	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	13,454	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	99,437	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 126,373	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	27,626	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 27,626	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,115	28
28a	Vending Machine Income	7,652	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,767	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,533,112	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	858,104	31
32	Health Care	2,429,641	32
33	General Administration	724,460	33
	B. Capital Expense		
34	Ownership	1,111,708	34
	C. Ancillary Expense		
35	Special Cost Centers	61,103	35
36	Provider Participation Fee	79,056	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,264,072	40
41	**Income before Income Taxes (line 30 minus line 40)****	269,040	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 269,040	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**
See attached schedule 19A

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,034	2,080	$ 60,114	$ 28.90	1
2	Assistant Director of Nursing	1,989	2,040	52,805	25.88	2
3	Registered Nurses	16,644	16,748	357,097	21.32	3
4	Licensed Practical Nurses	17,018	17,122	333,532	19.48	4
5	Nurse Aides & Orderlies	73,225	73,516	905,041	12.31	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,912	2,032	28,286	13.92	9
10	Activity Assistants	6,379	6,457	72,031	11.16	10
11	Social Service Workers	2,059	2,059	32,919	15.99	11
12	Dietician					12
13	Food Service Supervisor	1,531	1,643	27,576	16.78	13
14	Head Cook	6,448	6,448	68,976	10.70	14
15	Cook Helpers/Assistants	16,803	16,891	123,580	7.32	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,443	2,080	106,940	51.41	20
21	Assistant Administrator	1,273	1,240	21,967	17.72	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,965	5,831	84,719	14.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	155,723	156,187	$ 2,275,583 *	$ 14.57	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	171	$ 7,362	L1, C3	35
36	Medical Director	156	5,650	L9, C3	36
37	Medical Records Consultant	22	1,075	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,550	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	33	1,848	L11, C3	44
45	Social Service Consultant	27	1,485	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	409	$ 18,970		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,610	$ 226,038	L10, C3	50
51	Licensed Practical Nurses	1,669	64,922	L10, C3	51
52	Nurse Aides	3,082	89,283	L10, C3	52
53	TOTAL (lines 50 - 52)	9,361	$ 380,243		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Florina, Jr.	Administrator	10.00%	$ 106,940
Thomas Annarella	Asst. Administrator	0%	21,967
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 128,907

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
American Express Tax &		$
Business Services	Accounting	8,762
Achieve Software	Computer Services	120
Stratton, Dobbs & Nardulli	Legal	2,427
Stratton, Stone & Kopec	Legal	5,805
Porte Brown LLC	Accounting	2,845
Accurate Computer Services	Computer Services	1,015
Personnel Planners	U/C Consulting	648
Altschuler, Melvoin & Glasser LLP	Accounting	25,580
Patrick M. Loftus	Legal	1,091
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 48,293

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,193
Unemployment Compensation Insurance	11,320
FICA Taxes	172,682
Employee Health Insurance	65,021
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee 401k	12,000
Other employee benefits	11,303
TOTAL (agree to Schedule V, line 22, col.8)	$ 305,519

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	17,427
Health Care Worker Background Check	
(Indicate # of checks performed 40)	480
Illinois Health Care Association Dues	5,317
Miscellaneous Subscriptions	710
Miscellaneous Dues	140
Miscellaneous Licenses	810
Miscellaneous Permits	450
Miscellaneous Inspections	1,524
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,858

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Training & Education	1,133
Seminar Expense	2,949
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,082

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

The Arbor of Itasca
Provider #0019471
12/31/2000

Schedule 21A

XIX. Support Schedules
C. Professional Services

Total (agree to Schedule V, line 19, column 3)		$ 48,293
Nonallowable legal fees:		
Patrick M. Loftus	Legal	(1,091)
Stratton, Stone & Kopec	Legal	(51)
Itasca Shelter Care, L.L.C. allocation:		
Chapman and Cutler	Legal	7,526
		6,384
Total (agree to Schedule V, line 19, column 8)		$ 54,677

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Re-decorating Facility	July 97	$ 8,691	3	$ 1,449	$ 2,897	$ 2,897	$ 1,448	$	$	$	$	$
2	Re-decorating Facility	Feb 99	4,182	3			697	1,394	1,394	697			
3	Re-decorating Facility	June 99	2,484	3			414	828	828	414			
4	Air Conditioning Units	July 99	3,817	3			636	1,272	1,272	637			
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 19,174		$ 1,449	$ 2,897	$ 4,644	$ 4,942	$ 3,494	$ 1,748	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $5,317**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **n/a**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **6 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **78,146** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
n/a

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **79,056**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **n/a** Has any meal income been offset against related costs? **n/a** Indicate the amount. $ **n/a**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **n/a**
c. What percent of all travel expense relates to transportation of nurses and patients? **n/a**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **1099's prepared**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **n/a** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **n/a** If no, please explain. **n/a**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees